

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12064-63-043983**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 7 WEEKS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 4235 THOLOZAN		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR WILLIAM SADLER			4. DATE OF DEATH Month Day Year 12 - 6 - 63		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-5-90	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAFFIC MANAGER		10b. KIND OF BUSINESS OR INDUSTRY GRUNDLER CRUSHER		11. BIRTHPLACE (City and state or country) ST. LOUIS MO	
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME ARTHUR V. SADLER		13b. MOTHER'S MAIDEN NAME MARY ANN HERRINGTON	
14. NAME OF HUSBAND OR WIFE KATHRYN SADLER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Address KATHRYN SADLER 4235 THOLOZAN			

18. CAUSE OF DEATH (Enter only one cause per line for: PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, Bilateral		INTERVAL BETWEEN ONSET AND DEATH < 48 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Inanition		2 mos
DUE TO (c) Chronic Renal + Cardiac Failure		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 593x		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION: COUNTY STATE	
21. I attended the deceased from 11-17-63 to 12-6-63 and last saw him/her alive on 12-5-63 Death occurred at 8:00 A on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Deceased or title) Bernard T. Swanyk, MD		22b. ADDRESS St. John's Hospital		22c. DATE SIGNED 12-6-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-9-63	23c. NAME OF CEMETERY OR CREMATORY CALVARY		23d. LOCATION (City, town, or county) (State) ST. LOUIS MO.	
24. FUNERAL DIRECTOR ARTHUR J. DONNELLY		ADDRESS		25. DATE RECD. BY LOCAL REG. DEC 6 1963	
				26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4699

P. O. Address 3840 Lindall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.